NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

BOB ICB BOARD MEETING

Title	Verdict in the trial of Lucy Letby – initial response to letter from NHS England (18 August 2023)		
Paper Date:	6 September 2023	**Meeting Date:**	19 September 2023
Purpose:	Assurance	**Agenda Item:**	08
Author:	Rachael Corser, Chief Nursing Officer; Catherine Mountford, Director of Governance	**Exec Lead/ Senior Responsible Officer:**	Rachael Corser, Chief Nursing Officer

Executive Summary

The crimes committed by Lucy Letby were just awful and terrible. Our thoughts continue to be with the families, loved ones and staff who are closely involved. The public, and statutory, inquiry will commence in due course and will be led by Lady Justice Thirlwall.

This paper sets out the strategies in place across the ICB, and in our provider partners, to mitigate such horrendous and heartbreaking crimes, detailing the work in place to ensure all staff and partners have access to services that allow them the '*freedom to speak up*', when there are concerns with patient safety; that there is due diligence completed when appointing directors and senior managers and that the board remain focused on patient safety and quality of care.

The way the ICB continues to quality assure the services we commission is set out in the new Quality Assurance Framework on the agenda today.

Action Required

The board is asked to note this update.

Conflicts of Interest:	Conflict noted: conflicted party can remain and participate in discussion.

This report impacts on organisations that partner members of the Board lead/are employed by. The perspective of these members is an important aspect to enable the Board to focus on where the ICB (Integrated Care Board) and system contribute to improvement. Their input to discussion and reflection on what it means for the organisations they work in will assist the Board in its reflections.

Verdict in the trial of Lucy Letby – initial response to the letter from NHS England

Context

1. Following the outcome of the trial of Lucy Letby, NHS trusts and Integrated Care Boards have been asked by NHSE (letter in Annex 1) to ensure that:
   - All staff have easy access to information on how to speak up.
   - Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
   - Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.
   - Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well, with compassion and have access to the right support.
   - Boards are regularly reporting, reviewing, and acting upon available data. This includes notifying the ICB of any disclosures made of inappropriate clinical practice which may lead to patient harm, together with a detailed response of actions taken. This should include statutory reporting requirements set in legislation, relating to safeguarding responsibilities, or reports of criminal activity.
   - The letter also reminds organisations of their obligations under the Fit and Proper Person requirements.
2. The work in hand to respond to this is summarised in this report.

Immediate Actions

3. The ICB Chief Executive Officer (CEO) and Chief Nursing Officer (CNO) wrote to all our NHS Trusts highlighting our joint responsibilities to respond to the assurances being sought across the system, public and from our regional and national NHS England colleagues.
4. The Trusts have been thanked for taking the steps to respond to the actions and requirements and asked to confirm to the ICB when these responses are submitted to the national team and to share with us the assurances being taken to Trust Boards as soon as they become available. This area of work is being led by the ICB CNO.
5. Additional actions being picked up through the chief people officers and the chief medical and nursing officers, will evolve and continue to address emerging issues, as well as issues that will arise because of the Statutory Independent Inquiry ordered by the Secretary of State on 4 September. It is essential that the ICB responds expeditiously to any matters of concern in BOB provider organisations as soon as they arise.

ICB responsibilities under Freedom to Speak Up

6. The role of Freedom to Speak Up (FTSU) guardians and the National Guardian were established in 2016 following the events at Mid-Staffordshire NHS Foundation Trust and recommendations from Sir Robert Francis' Freedom to Speak Up Inquiry.
7. On establishment the ICB appointed Sim Scavazza, in her role as Deputy Chair/Chair of the People Committee as the NED lead for FTSU. She is supported in this role by the Director of Governance. The initial focus was on ensuring that ICB staff have a FTSU route to use, and there is a system currently in place that enables this. We know that our approach needs to develop and an important part of this is ensuring that the organisational culture supports members of staff to feel empowered to speak up, with no barriers or fear of recrimination and for there to be a range of routes/opportunities, not just FTSU, for them to do this. We will involve our staff to ensure that we have in place mechanisms that are accessible and supportive to cover different circumstances.

8. NHS England and the National Guardian Office published an updated Freedom to Speak Up Guide and Implementation Tool in June 2023 which sets the following expectations for ICB/ICS organisation to help improve access to the FTSU service, as summarised below:
   - 30 January 2024 – ICBs to have a FTSU Guardian in post.
   - December 2024 – ICBs to put in place FTSU Guardian for primary care workers.
   - December 2024 – ICBs to gain assurance that staff across the ICS have access to a FTSU Guardian.
9. We are currently reviewing the guide and will prepare options for meeting these requirements which will be considered by the People Committee in October and then be presented to the November Board meeting. In the interim we have put in place a mechanism to support general practice through an ICB managed generic inbox with support from a previous CCG FTSU guardian.
10. The information through Trusts' F2SU reports and from Primary Care forms part of our overall quality assurance mechanisms and the approach to this is outlined in paragraphs 17-19.

Fit and Proper Person Test for Board members

11. On 2 August NHSE published the Fit and Proper Person Test (FPPT) Framework. This is in response to the recommendations made by Tom Kark KC in his 2019 Review of the FPPT. The Framework also considers the requirements of the Care Quality Commission in relation to directors being fit and proper for their roles.
12. The FPPT applies to executive and non-executive directors of integrated care boards, NHS trusts and foundation trusts, NHS England, and Care Quality Commission – interim as well as permanent appointments.
13. The steps we need to take to implement the framework are:
    - Advise Board members of the areas that will be considered under FPPT assessment, the details that will be stored on the electronic staff record and who will have access to this data.
    - From 30 September 2023, use the new board reference template for references for all new board appointments.
    - From 30 September 2023, complete and retain locally the new board member reference for any board member who leaves their position for whatever reason, and record whether or not a reference has been requested.
14. NHSE are currently finalising a new NHS Leadership Competency Framework (LCF) for board level roles. This will be shared by the end of September, so that it can be implemented by 31 March 2024, alongside the FPPT Framework.
15. A new board appraisal framework will also be published, incorporating the LCF, by March 2024 and we will be expected to use this for annual appraisals of all board directors for 2023/24.
16. The Director of Governance and Chief People Officer are working together to ensure we implement this effectively for the ICB and we will be writing to all Board members to explain the requirements.

Approach to Quality Assurance

17. Our Quality Assurance Framework (being presented to the Board under Item 10 today) was agreed by the Population Health and Patient Experience Committee in June (PHPE) and we take regular reports to PHPE and through our System Quality Group (SQG) detailing key quality and safety outcomes in relation to the services we commission, including deep dives into maternity and neonatal services.
18. Oversight of mortality data and the implementation across the ICS of the medical examiner role is done through our mortality review group. We will continue to monitor the trends and changes in data relating to mortality and harms through this group, into our system quality group and up to the PHPE.

19. Regular weekly reporting of Serious Incidents (SI) will include identification of any trends, particularly from a specific service or at a particular time. Incidents now being reviewed under the new Patient Safety Incident Review Framework (PSIRF) allow for the system to look in detail at cases that previously would not meet threshold or would be considered a 'near miss'. Thus, the system will be able to review cases where there was no harm, but where there may have been had remedial action not been taken. Reports from SI panels will be presented and discussed at our SQG and summarised for assurance purposes at PHPE.

Matters to Consider

20. Employees have a right to support for any issues arising in their working relationships or practices, and as was seen in the Letby case, the Trust was forced to undertake a review of the concerns around Letby, (prior to police involvement) and subsequently apologise to her for the way it had approached the investigation.
21. Where there are concerns of this nature and it is felt that employment rights are overshadowing the concerns, the ICB should support the providers to seek independent, impartial input and oversight.
22. Where the concerns very clearly relate to criminal activity, the provider should involve the police without delay and advise the ICB of this immediately.

Summary and Next Steps

23. Whilst the Letby case related to one specific area of healthcare, extremely sick neonates, the principles of learning from the case could impact any area of healthcare or indeed public service. It is an ugly truth that although rare, sometimes people come into the caring profession specifically to cause harm. A professional qualification provides opportunities and often a smokescreen for perpetrators to access vulnerable people.
24. The system should apply measured and proportionate structures to minimise the risk of professionals acting in ways that are not only outside of clinical guidance, but in some cases, as in Letby, are criminal in nature.
25. The Board are asked to consider the contents of this report, seek assurances of the current arrangements to manage FTSU or allegations against staff and arrange a timely review of BOB provider processes.

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

18 August 2023

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for

communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer, England

Professor Sir Stephen Powis
National Medical Director
NHS England